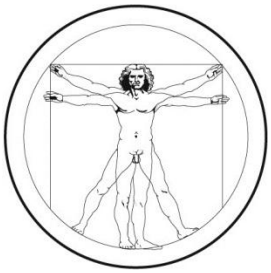

Platte River Medical Clinic
Family Care and Women's Health
2801 Purcell Street · Brighton, CO 80601 · (p) 303.659.7600 (f) 303.558.8223

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print)
Name:_____
Date of Birth:_____SS#_____
Address:_____
City:_____State:_____Zip Code:_____
Home Phone:_____Cell/Work/Other:_____

RELEASE MOST RECENT PHYSICAL EXAM FINDINGS INCLUDING: Medications and Complete Problem List, Labs, Pathology, EKG, PAP, and Mammogram reports. If a child, please include, complete immunizations history.
SPECIFIC RECORDS ONLY:_____

Release my Medical Records **FROM:**

Name:_____
Phone:_____
Fax:_____

TO:
Platte River Medical Clinic
2801 Purcell Street
Brighton, CO 80601
(p) 303.659.7600 (f) 303.558.8223

I understand that my medical records are protected under State and Federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections, including testing and treatment for HIV/AIDS, and diagnosis of mental illness or psychiatric care cannot be released without my written consent. Please initial the line below if you DO NOT want any of the following records to be released. All applicable records will be released if nothing is marked or noted.
_____ Drug and/or alcohol abuse, diagnosis or treatment
_____ HIV/AIDS testing and/or treatment
_____ Psychiatric care and/or mental illness
_____ Confirmed STD test results and/or treatment

Please release a copy of all my medical records. This release will be valid for 1 year from the date of signature.

BY MY SIGNATURE I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS

_____/_____/_____
Patient Signature Printed Signature Date